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LET US BE PRACTICAL ABOUT THE PSYCHONEUROSES*

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MANY modern papers presented to general practitioners on the psychoneuroses are written by psychiatrists who seem to fail entirely to appreciate the family doctor's problems in dealing with these patients. The fact is that, if his office hours are from, say 2 to 4 p.m., and if there are, to be conservative, ten patients in the waiting room, the doctor has an average of twelve minutes per patient. Perhaps some of these are returns who can be dealt with very quickly so that he may be able to give twenty or even thirty minutes to a new patient. But, if modern figures are correct that at least one-third of his patients are psychoneurotic cases, the busy practitioner's greatest problem is how to deal with these patients quickly and yet effectively.

The fact must be faced that the family doctor, even if he has the training, simply does not have time to make a complete psychiatric study of each psychoneurotic patient he sees. There is the tendency on the part of psychiatrists to be too critical of him as he does the best he can with the time at his disposal. It is true that the psychiatrist sees, very frequently, the unfortunate results of the general practitioner's hurried therapeutic efforts. Yet I wonder how much better the psychiatrist would do under similar circumstances.

It would seem to be the common practice of many physicians to listen briefly to the patient's story, interrupting him frequently to elicit bare symptoms and their time of onset, and never giving the patient sufficient time to express himself fully. Often the physical examination is cursory or is confined to the areas of the body complained of. Only rarely is the patient asked to strip sufficiently for a complete physical examination. When no cause for the patient's symptoms is found he is given a pat on the back, a hearty assurance that it is just his nerves, and a bottle of bromides.

In the case of the patient with a mild anxiety state, whose attention has become focussed on his own health and whose emotional tension has become centred on fears of some malignant disease, this treatment is often effective for the time being. He thanks the doctor for lifting a load off his mind and leaves the office feeling better. A bottle or two of the sedative makes him less conscious of his "neuromuscular hypertension".[6] Whereupon he may be able to attack the original environmental cause of his emotional tension. Not infrequently, however, this patient turns up in the doctor's office some weeks or months later with the same or more severe complaints. He wants another bottle of the same medicine that "cured" him before. Unfortunately this does not work as well the second or third time and the patient is apt to say that the medicine was different. Then begins a series of visits with the patient becoming more and more dissatisfied and complaining and the doctor becoming seemingly less and less interested or even annoyed. Eventually the patient stops going to that doctor's office and joins the crowd in another doctor's waiting room or becomes a source of income to the chiropractor or herbalist.

WHAT CAN WE DO ABOUT IT?

What is the answer to this problem? To my mind it consists of three aspects; more time; a different approach; a definite program of treatment.

In spite of what I have said before, I, too, must insist that the psychoneurotic patient cannot be treated adequately in a twenty-minute interview nor even in a series of them. You will agree that you have to give more time to your cases with organic disease, especially to the surgical cases. I wish I could convince

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the physician that the psychoneurotic case needs just as much time and just as thorough an investigation as the surgical case. A time must be set aside for one or two long interviews for history-taking, examination, diagnosis and initial treatment. This will be followed by a series of shorter office visits for reassurance and explanation which may have to be given over and over again from time to time.

The approach must be one of studiously unhurried interest. The initial twenty minute interview will be sufficient to convince the physician that the case has an emotional angle to it. That is the indication for giving no advice until an hour can be commandeered for an appointment for the patient. The first essential in this interview is to let the patient tell his story in his own way; let him talk himself out; relieve his feelings; get it off his chest. In so doing you have started his treatment even as you gather material for your diagnosis. It is after this that you ask your questions, taking your cues from his story, make your functional inquiry, and physical examination. In case you have a tendency, that I have noticed in myself, to curtail the functional inquiry for fear of suggesting new symptoms, I must warn of the necessity of covering every detail while you are at it, to avoid giving the patient the opportunity of mentioning additional symptoms at a later date and accusing you of not having asked about them. Do not be in a hurry to make a diagnosis and do not be in a hurry to give advice. To do this patient good you must make an impression on him of taking him seriously and of giving his case your earnest consideration. Once you have made your investigation to your entire satisfaction do not permit yourself to be wheedled into giving him additional tests or examinations.

The treatment must be definite. It will consist of definite statements of explanation, reassurance, and the setting up of a definite program. The doctor who hesitates, who says, "I think thus and so is probably your condition," or, "This will likely help you," will never cure the psychoneurotic patient. He needs positive statements and concrete orders.

SYMPTOMS AND SIGNS AS CUES

With the hope of shortening the time that the physician will need to spend with the patient, I am going to risk making some statements about the possible significance of some of the common psychoneurotic symptoms. In offering these suggestions the author is aware of the danger of making them and wants to make it plain that they are suggestions only and not hard and fast rules or proved facts that apply to every patient. It would take a book to discuss adequately all the symptoms you will meet so I shall attempt to discuss very briefly only a few of those which are more commonly encountered.

1. *Poor concentration.*—The patient who says he cannot concentrate and hence cannot read or study or do his work efficiently is suffering from anxiety. He is usually anxious about his condition, of course, but this is a substitute for his real anxiety which often arises from some conflict of emotions. He wants to do something but dare not. He is doing something but fears the consequences even while he continues to do it. The possibility of masturbation, having an affair, or homosexual practices should be thought of.

2. *Failure of memory.* — The non-organic memory loss complained of by some patients, if not due to hysteria, is likely due to poor concentration, the cause of which has been noted previously. The amnesia of hysteria is quite another thing and such cases should be handled by a psychiatrist.

3. *Fatigue on slight exertion.*—If no physical cause can be found for the patient's complaint of tiring easily, this condition is almost sure to be the result of anxiety due to emotional conflict. This is the cause also of disturbed sleep followed by morning fatigue.

4. *Chronic fatigue.*—The patient who says, "Doctor, I'm tired all the time. I just haven't the energy to do anything", is reacting to a failure to accept a disliked condition which cannot be changed. The patient's concern over his tiredness makes him still more tired so that a vicious circle is set up.

5. *Palpitation.*—We are a heart-conscious race and are being made more so by warnings of physicians and by medical propaganda in newspapers, and radio broadcasts. The heart naturally beats faster and harder when we are afraid or angry. It is made hypersensitive by anxiety, a form of fear, and by dissatisfaction, a form of anger. Once palpitation has been experienced, however, patients become anxious for fear it is serious and will occur again with

fatal results. While it is occurring fear may increase to panic proportions at times. These anxiety attacks will not be cured by allaying the patient's fears about his heart. The attacks will recur even if the patient is taught not to become panicky about them, unless the chronic basic fear or dissatisfaction is unearthed and dealt with.

6. *Respiratory difficulty.*—The patient who complains of difficulty in breathing is always apprehensive about it, regards it as serious and usually thinks of it as evidence of heart disease. So frequently the basic cause of this symptom is fear regarding sex practices of which the patient is ashamed. He feels he has sinned and fears death. His rapid, shallow breathing may produce an alkalosis with the symptoms of tetany such as pricking sensations and muscle spasms.[2] Hyperventilation may signify a fear of impending embarrassment.

7. *Deep sighing.*—This suggests sadness, anxiety, a load on the chest, causing emotional tension.

8. *Polyuria and diarrhœa.*—These are usually the result of fear or excitement. They may be manifestations of a fear of exhibiting oneself in public places.

9. *Intestinal tension.*—The patient who is concerned about "feeling a knot in the pit of the stomach" or about intestinal cramps or rumblings at times needs to learn that such an experience is normal for many people during or after a period of strong emotion. Especially is this true of those who give freely of their sympathy or who use large amounts of emotional energy in attempting to influence others. They must be taught not to become panicky over this condition since to do so will tend to aggravate it or make it chronic. It must be accepted as normal and must be put up with as it will pass off as one tries to relax. The frequent occurrence of this symptom should be regarded as a warning signal that a period of relaxation is necessary.

10. *Nervous indigestion.*—This is a common modern diagnosis used freely by many general practitioners without adequate explanation. Many patients accept their condition as being caused by their nerves and therefore unavoidable and incurable, and regard themselves as chronic invalids. Patients need to know more specifically what causes their non-organic gastro-intestinal symptoms and signs. Depression and anger, from whatever cause, inhibit gastric and duodenal secretions and slow up peristalsis with resultant fermentation and putrefaction of food, gas formation, belching or flatus and constipation. Excitement and anxiety tend to increase gastric acidity and peristalsis with rapid emptying of the stomach, gnawing hunger pains, acid eructations, and often diarrhœa. Disgust or resentment decreases gastric acidity but seems to increase bile flow and causes reverse gastric peristalsis with vomiting.[5] Excessive appetite[3] with overeating and a tendency to obesity is a form of substitute gratification for deep-seated dissatisfactions or longings, and is a protective mechanism originally, but may become simply a habit.

11. *Psychic amenorrhœa.*—May be due to fear of pregnancy or desire for the same.[4]

12. *Psychic menorrhagia and psychic dyspareunia.*—These are fear mechanisms that protect the patient from unwanted sexual intercourse. They are often based on the fear of pregnancy, fear of disease or sex practices of the husband that are abhorrent to the patient.

13. *Headache.*—This is one of the commonest symptoms of psychoneurosis, and as such is often a headache to the family doctor. Every physician is aware of the multiplicity of causes for headache. The question regarding whether the cause of the headache is predominantly organic or predominantly emotional in origin has to be considered for each case. No general practitioner can find time to do all the tests advocated to rule out an organic cause. As a minimum a general physical and neurological examination is indicated. This should include an examination of the fundi and rough vision-field tests. The description of the headache, its location, time of occurrence, and the patient's activities at the time of its onset are important. Those coincident with worry or excitement certainly have a large psychic factor in their cause. The headache that is sometimes forgotten when the patient has something interesting to do is not likely organic in nature. A psychic etiology should be thought of when the patient who says he has headache continuously shows none of the accompanying signs of suffering. The more vague the description of the headache the more

likely is its cause to be psychogenic. One should look for emotional causes also when the headache is made worse by talking about it. The headache that begins at the back of the neck and radiates forward is due to muscle tension which is predominantly emotional in origin. It is wise to postpone making a diagnosis of the cause of the headache until one has talked with at least one other member of the patient's family. Such a person will throw light quite often on the disturbing environmental situations which the patient may have kept hidden.

14. *Fear of injuring someone or of suicide.*—The patient who complains of a fear that he may harm someone, or may commit suicide often has a wish to do these things but a fear of the consequences. He should be taken out of the disturbing environment for a period.

15. *Inferiority feelings.* — Patients may feel inferior to others intellectually, morally, socially, or physically. Seldom need a person be inferior in all of these fields. Inferiorities in one respect may be offset by successes in one or more of the others. The physically homely or handicapped may become socially acceptable because of his intellectual achievement or moral excellence. A happy and satisfying religious life is the best antidote for inferiority feelings.

16. *The loud complainer.*—The patient who complains loudly about seemingly unimportant things is hiding from himself and others the real cause of his anxiety, even though he does not realize the fact. A case in point is an eighty-five-year-old man complaining bitterly of his feet, kidneys, back, eyes, sleeplessness, continual agony of malaise, and fear of death, who fails completely to realize that the real source of his trouble is his religious conflict and his unwillingness to make his peace with his God.

17. *Clinging dependence.*—The person to whom the psychoneurotic patient clings most markedly and whom he demands to have with him continually is closely associated with the source of his trouble. It is usually necessary to separate the patient from this person for a considerable period of time before the truth comes to light. The patient will be found to have conflicting emotions about that person and guilt feelings because of his conflicts.

THE NEED FOR A CHANGED ATTITUDE

Because patients' attitudes are changing.—Doubtless from earliest times there have been patients who came to their physician convinced that they knew what the cause of their trouble was and how it should be treated. There are more of them today, thanks to magazine articles, syndicated newspaper articles by doctors, radio talks and advertisements *ad infinitum*. No longer is the physician's word accepted without question. We are faced with the necessity of giving reasons for our decisions. The patient demands explanations which the physician is often hard put to it to provide in a brief period of time. His responsibility has increased considerably since he can do so much harm by hurried half-explanations that may be misunderstood entirely. Moreover, the patient's emotional tensions are not infrequently aggravated by the seemingly conflicting explanations of two or more physicians. As a profession we owe it to our patients as well as to ourselves to be more definite about our statements.

Because psychoneurotics are sick people.—It cannot be reiterated too frequently that psychoneurosis is not caused by perverseness of character or wilful lack of will power. The patient should not be blamed for his condition by the physician, nor should any hint be dropped that his relatives could seize upon to blame him at home.

Because the public are becoming psychiatry-conscious. — Many patients tell me they think their trouble is mental rather than physical before I get a chance to tell them so. In spite of this they usually are quite misinformed about the real cause of their trouble and often need more straightening out in their ideas than those who think their symptoms are physical in origin.

CONCLUSIONS

The family doctor has always treated the psychoneurotic patient whether or not he made such a diagnosis. If he is not to lose 30 to 50% of his patients he will still have to treat this type of illness. He is quite capable of doing so in most instances and, indeed, is the logical person for the work. His need is for a plan of procedure such as I have attempted to indicate both in this article and in a previous one.[1] He must have faith in himself since he has to radi-

ate confidence to his patients. He would do well to recapture some of the authority of his predecessor of the horse-and-buggy days.

The psychoneurotic patient needs a chance to unburden himself; reassurance; positive suggestion; accurate explanation suited to his intelligence; a plan for living; exhortation; and an assurance of his physician's unfailing interest and desire to help him at all times.

Two things bear emphasizing. First, the fallacy of telling psychoneurotic patients they are all worn out and putting them to bed to brood about their troubles. It is often easier to get them to bed than to get them up again. The emphasis should be upon relaxation through exercise, massage, a hobby, social activities, or change of environment, rather than upon just plain rest. In most of these cases a change is better than a rest.

Second, psychoneurotic patients are stimulating to the conscientious physician. They keep him on his toes. They challenge his best diagnostic ability and best therapeutic ability. The battle is half won as far as these cases are concerned when the physician stops nursing his phobia regarding them and determines to meet the challenge they present.

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INDICATIONS FOR SPLENECTOMY*

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THE spleen was spoken of by Galen as an organ "full of mystery" and even after the passing of many years the statement can be said to be more or less true.

It is also interesting to note that with the passing years certain traditions have arisen relative to the association of the spleen with laughter and good humour and with the ability to run fast. In an old English translation by Holland of the "Natural History" of C. Pliny (23 to 79 A.D.) the following statement is found:

> "This member (the spleen) hath a proprietie by itself sometimes to hinder a man's running; whereupon professed runners in the race that be troubled with the splene have a device to burn and waste it with a hot yron. And no marveils; for why? They say that the splene may be taken out of the body by way of incision and yet the creature live nevertheless; but if it be man or woman that is cut for the splene, he or she looseth their laughter by the means. For sure it is that intemprat laughers have always great splenes."

Shakespeare also spoke of both these functions of the spleen. In "Twelfth Night", III, ii, 72, Maria ridicules Malvolio before Sir Toby and says: "If you desire the spleen and will laugh yourself into stitches, follow me". In "King John", V. iii, 49, the Bastard says:

> "I am scalded with my violent motion
> And spleen of speed to see your majesty."

In modern times, the surgeon does not remove spleens in an attempt to either increase his patient's ability to run fast or to modulate a hearty laugh. There are at times certain definite indications for splenectomy, such as, when a spleen has been ruptured and the patient is bleeding into the abdominal cavity. However, the indications are not always so definite and a surgeon faced with the problem of a patient suffering from splenomegaly resulting from certain diseases has been uncertain as to what results to expect from splenectomy. Apparently, for reasons that are not well-defined, the results of splenectomy have varied considerably and it is only in recent years that the problem has begun to resolve itself. The following paper is an attempt to outline some of the indications and contraindications for splenectomy.

THE MATERIAL STUDIED

This paper consisted of the records of the Vancouver General Hospital and the recent medical literature. The records of the Vancouver General Hospital revealed 44 splenectomies from 1936 to 1944 inclusive. These, because of the paucity of cases of any one type, did not seem of sufficient value for detailed study and were abandoned.

The literature was then studied and found to contain a confusing number of poorly reported and poorly followed-up series of splenectomies, and most of the reports were considered of

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